Medicare Plan Comparison Chart

Covered Services	Medicare HMO Blue	Managed Blue For Seniors	Harvard Pilgrim Medicare Enhance
Contribution Rate	$29.30 per month	$37.79 per month	$40.80 per month
Residence Eligibility	Reside in Plan Service area	Reside in Plan Service area	Reside anywhere in the United States or one of its territories
Office Visits	PCP visits – $15 Specialist visits – $35 Annual physical – $0	$10 copay per visit	$15 copay per visit $0 for annual physical
Prescription Drugs Purchased at Participating Pharmacies	Up to a 30-day supply: Generic – $10 copay Preferred brand name – $25 copay Non-preferred brand name – $45 copay	Up to a 60-day supply: Generic – 25% copay Brand name – 50% copay Non-formulary – 75% copay	Up to a 30-day supply: Generic – $10 copay Select brand – $20 copay Non-select brand – $35 copay
Prescription Drugs Purchased by Mail Order	Up to a 90-day supply: Generic – $20 copay Preferred brand name – $50 copay Non-preferred brand name – $90 copay	Up to a 90-day supply: Generic – $5 copay Brand name – $30 copay Non-formulary – $50 copay	Up to a 90 day supply: Generic – $20 copay Select brand – $40 copay Non-select brand – $105 copay
Inpatient Care in an Acute Care Hospital	Member pays $150/day for days 1 – 5 (up to $750 per admission), then covered in full	Covered in full	Covered in full
Inpatient Care in Skilled Nursing Facility Care (SNF)	Member pays $40/day for days 1 – 20; $100/day for days 21 – 44; $0 per day for days 45 – 100. Coverage for up to 100 days per benefit period[1]	Covered in full for up to 100 days per benefit period[1]. You must have been hospitalized three or more days in a row and transferred to the SNF within 30 days of the hospital discharge.	Covered in full for up to 100 days per benefit period[1]
Emergency Care at a Hospital Emergency Room	$65 copay, waived if admitted	$50 copay, waived if admitted	$50 copay, waived if admitted to hospital
Ambulance Services	$100 copay, waived if admitted within 24 hours of trip. Covered in full for trips between hospital and Skilled Nursing Facility.	$40 copay for medically necessary transport. Full coverage for emergency transport.	Medicare approved ambulance services covered at 100%
Dental Care	After you pay a $35 copay per visit, you are covered every six months for: 1 cleaning; 1 oral exam, including one set of bitewing X-rays	No coverage for routine dental care	No coverage for routine dental care
Chiropractic Services	$20 copay per visit including spinal manipulation services furnished by a Chiropractor	$10 copay per visit including spinal manipulation services furnished by a Chiropractor	Covered for Medicare-approved services with a $15 copay
Eyeglasses	Up to $150 once every 24 months for eyewear including fittings and evaluations	Discounts from participating providers	One pair of eyeglasses or contact lenses after each cataract surgery
Hearing Aids	Covered up to $400 every 36 months	Not Covered	Not Covered

[1] Benefit Period: The time period defined by Medicare to determine when coverage in a hospital or Skilled Nursing Facility starts and ends. A benefit period starts on the first day a beneficiary receives care in a hospital or Skilled Nursing Facility and ends when the beneficiary has not received care in a hospital or Skilled Nursing Facility for 60 days in a row.

Covered Services	Tufts Medicare Preferred HMO	Tufts Medicare Preferred Supplement/PDP	Master Medical Carve-Out A&B
Contribution Rate	$28.80 per month	$40.00 per month	$131.56 per month
Residence Eligibility	Reside in Plan Service area	Reside anywhere in the United States or one of its territories	Reside anywhere in the United States or one of its territories
Office Visits	PCP Visits – $10 copay Specialist Visits – $15 copay Annual physical – $0 copay	$10 copay per visit $0 for annual physical	After you pay the $50 Extended Benefits deductible, you pay 20% of allowed charges
Prescription Drugs Purchased At Participating Pharmacies	Up to a 30 day supply: Tier 1 – $10 copay Tier 2 – $25 copay Tier 3 – $50 copay	Up to a 30-day supply: Tier 1 – $5 copay Tier 2 – $10 copay Tier 3 – $25 copay	You pay 20% co-insurance. When the 20% co-insurance reaches $200 in a calendar year, you are then covered in full for the rest of that calendar year
Prescription Drugs Purchased by Mail Order	Up to a 90 day supply: Tier 1 – $20 copay Tier 2 – $50 copay Tier 3 – $100 copay (copays less for 30 or 60 day supply)	Up to a 90-day supply: Tier 1 – $10 copay Tier 2 – $20 copay Tier 3 – $75 copay	Up to a 90-day supply: Generic – $5 copay Brand name – $10 copay
Inpatient Care in an Acute Care Hospital	Covered in full after one time annual deductible of $300	Covered in full	Covered in full
Inpatient Care in Skilled Nursing Facility Care (SNF)	Covered in full for up to 100 days per benefit period[1]	Covered in full for 100 days per benefit period[1] after 3-day inpatient hospital stay	Covered in full. You must have been hospitalized three or more days in a row and transferred to the SNF within 30 days of the hospital discharge
Emergency Care at a Hospital Emergency Room	$50 copay, waived if admitted to hospital	$50 copay, waived if admitted to hospital	Covered in full for hospital charges; After you pay the $50 Extended Benefits deductible, you pay 20% of allowed charges for provider services.
Ambulance Services	Medicare approved ambulance services covered with a $50 copay per day	Medicare approved ambulance services covered at 100%	20% co-insurance for medically necessary transport. Full coverage for transporting inpatient between hospital and Skilled Nursing Facility and back.
Dental Care	No coverage for routine dental care	No coverage for routine dental care	No coverage for routine dental care
Chiropractic Services	Covered for Medicare approved services with a $15 copay	Covered for Medicare approved services with a $10 copay	You pay 20% co-insurance
Eyeglasses	$150 per year towards eyewear or contact lenses, but not both	$150 reimbursement per year towards eyewear or contact lenses, but not both	Discounts from participating providers
Hearing Aids	Covered up to $500 for the purchase or repair of hearing aids every three years	Members reimbursed for first $500 (covered in full); then for 80% of next $1,500, up to a total of $1,700 every 2 years	Not Covered

[1] Benefit Period: The time period defined by Medicare to determine when coverage in a hospital or Skilled Nursing Facility starts and ends. A benefit period starts on the first day a beneficiary receives care in a hospital or Skilled Nursing Facility and ends when the beneficiary has not received care in a hospital or Skilled Nursing Facility for 60 days in a row.